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DEPARTMENT OF HE	ALTH AND HU	MAN SERVICES
CENTERS FOR MEDI	CARE & MEDIC	AID SERVICES

PRINTED: 02/15/2008 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3 · DATE SURVEY COMPLETED	
-		09GD10	B. WING _	the first of the second of the	12/0	8/2008
NAME OF P	ROVIDER OR SUF	'U.ER	6	REET ADDRESS. CITY, STATE, ZIP CODE 1417 KANSAS AVE, NE WASHINGTON, DC 20001	1 0270	4
(X4) ID PREFIX TAG	(EACH DEFI	RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRINCED TO THE APPRINCE)	VLD 3E	(X5) COMPLETION DAYE
W 000	INITIAL CON	VIENTS	W 000			
W 120	February 5, 2 survey was Ir process. A reselected from with various of survey were It with one client programs, as administrative Investigation 483.410(d)(3) OUTSIDE SC The facility meet the need the sample (C The finding in On February 6 Client #2 was floor while end staff person. Specialist (AT was one of Ci Further interviday program of challenging be Antecedent Bibecause the control of the survey of the sample (C) Further intervidation of the survey of the	Ist assure that outside services is of each client.  RD is not met as evidenced by: anration, interview and record lifty falled to ensure that outside is needs of one of three clients in lient #2).	W 120	The QMRP will coordinate with the day ensure that the BSP is implemented as that data is collected, and reviewed, at a as described by the plan.	writt to and	DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 3
	DIRECTOR'S OR	REMIDER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	TITLE	<del></del> ·	(X4) DATE
Marso	a S. S.	mpon	2	ivertor of Disability Service	<b>.</b>	2/25/08

Whitetor of busility services Any deficiency statement ending with an autensk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey who her or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these of surnents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to confinued program participation.

FORM CMS-2587(02-98) Previous V irsians Obsolets

Event ID: YLYG11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PEINTED: 02/15/2008 FORM APPROVED OI<u>/IB NO. 0938-0391</u>

	F CORRECTION	IDENTIFICATION NUMBER;	A. EUN	DITIPLE CONSTRUCTION  DING	(X3) DATE SI COMPLE	
		09G010	B. WIN	G	02/0	8/2008
CARECO	PROVIDER OR SUF	<sup>7</sup> UER		STREET ADDRESS, CITY, STATE, ZIP COL 6417 KANSAS AVE, NE WASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEF	RY STATEMENT OF DEFICIENCIES  OF THE PRECEDED BY FULL  YOR LSC DENTIFYING INFORMATION)	ID PREFII YAG		SHOULD BE	(X5) COMPLETION DATE
W 120	home about of data on this to a linterview with Professional approximately program was Client #2 spit Support Plan program BSF 5, 2008 listec	ne decision discontinue collecting	W 1	. ·		
	revealed that "Spitting on the should be don Client #2's log failed to evide spitting behavior the day programmer 5, 2 administered the medical represcribed to	Client #2's BSP for the facility listed e floor" as a target behaviors and urnented as it occurs. Review of book kept by the AM 1:1 staff note of documentation when the floor occurred on February 6, 2008 at				
W 124	The facility m Therefore the parent (if the of the client's and behavior treatment, an	PROTECTION OF CLIENTS  Ist ensure the rights of all clients. Ifacility must inform each client, Ident is a minor), or legal guardian, medical condition, developmental al status, attendant risks of I of the right to refuse treatment.	W 1	24		
	This STAND/	RD is not met as evidenced by:	_			

FORM CM\$-2587(02-99) Previous remions Obsoleta

Event ID; YLYG11

Facility ID: 09G010

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**2**1007

PR NTED: 02/15/2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>ON B N</u>O. 0938-0391. STATEMENT OF DEFICIENCIES (X1) PROMDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 09G010 02/08/2008 NAME OF PROVIDER OR SUPFLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE CARECO 01 WASHINGTON, DC 20001 SUMMALY ISTATEMENT OF DEFICIENCIES (EACH DEFILIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX TAG (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD (E PREFIX REGULATOR 'OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY W 124 Continued From page 2 W 124 Based on observation, interview and record review, the far lility falled to ensure the right of each client or heir legal guardian to be informed of the client's insidical condition, developmental and behaviors status, attendant risks of treatment, and the right to refuse treatment for two of four clients residing in the facility. (Client #1, #2 and #3 The findings include: 1. The QMRP will ensure that the client's redical Interview v₁ th the evening medication nurse on. decision-maker is informed in writing of the health February 5, 2( 08) at approximately 5:33 PM benefits and risks of recommended treatmer ts revealed that : lient #1 was administered Paxil (including the BSP if it provides for restrictive 12.5 mg with I axil 25 mg each morning for measures), and will obtain written consent for such anxiety/depret sipn. Interview with the Qualified 3/25/68 treatments. Mental Retarc ation Professional (QMRP) on February 5, 20 08 at 3:19 PM revealed that Client #1 had an involved sisters that signs consent for treatment. Review of Client #1's Psychological Assessment on February 7, 2008 at approximately 3:11 PM revealed that the client did not evidence the capacity to make independent decisions on his behalf regarding his habilitation. planning, treat nent placement, financial, and medical matte s. There was no documented evidence that he facility informed Client #1 or a legally-authori led representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic

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medications and corresponding BSP.

a legally recognized individual or entity.

Additionally, the facility failed to provide evidence that substitute i consent had been obtained from

2. During the medication pass on February 5, 2008 at 5:13 F M, Client #2 was administered

Clonazepam 1 mig, Carbamazepine 200 mg, Risperdal 1 m j, and Hydroxyzine 25 mg by

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See response to #1 above.

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DEPAR	TMENT OF H	EALTH	HAND HUMAN SERVICES					D: <mark>02/15/2</mark> 008
			& MEDICAID SERVICES					APPROVED
STATEMEN	T OF DEFICIENCE OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I. A. BU		TIPLE CONSTRUCTION DING	(23) DATE S	
			09G010	e, wi	NG,			
NAME OF F	ROVIDER OR SU	PLIER			T	TUEST ADDRESS A	02/0	08/2008
CARECO	0 01				l	TREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE WASHINGTON, DC 20001		
(X4) LD PREFIX TAG	(EACH DE	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 124	Continued F	בם חוס	toe 3	10/	 10.	4		
	mouth. Inter Nurse (LPN) 5:40 PM revi prescribed fithe client's c 7, 2008 at a the psychotra a Behavior 5, 5, 2007, to a physical agg scratching of inappropriate complete task destruction, is smearing fec	view woon the a ed to remain the proximal proximal dress ession ters), times (s), se ublic res, and se, and se	with the Licensed Practical same day at approximately that the medication was adaptive behaviors. Review of physicians orders on February mately 9:54 AM revealed that adications was incorporated in Plan (BSP) dated December behaviors associated with a (hitting, spitting at, and sitting on the floor (at usually when asked to diff-injurious behaviors, property masturbation (grabbing genital, diciothes stripping.	W	124	4		
	Professional PM revealed mother that sof Client #2's February 8, 2's revealed that capacity to mother that regard treatment planatters. The that the facilities allow medications: Additionally, I's that substitute a legally reccurrences. Interview v. February 5, 2	CMRI that Clighs con Psych 008 at the cli ake income was / infoncized rependite the facing of constitutions of the facing of the faci	ualified Mental Retardation P) on February 5, 2008 at 3;20 lient #2 has an involved consent for treatment. Review clogical Assessment on approximately 9:04 AM ent did not evidence the dependent decisions on his habilitation planning, It, financial, and medical in no documented evidence med Client #2 or a epresentative, as appropriate, is and risks of treatment use of his psychotropic cresponding BSP. lity falled to provide evidence sent had been obtained from individual or entity.  evening medication nurse on approximately 5:24 PM		•	3. The QMRP will coordinate with the U	)D,	
	revealed that	Client:	approximately 5:24 PM #3 is administered Wellbutrin			support coordinator (formerly known as manager) to apply for a medical guardia	the case	2/26/28

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Event ID: YLYG11

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PR NTED: 02/15/2008 DEPARTMENT OF HE ALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARD SERVICES <u>ONB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES. AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED a. Building B. WING 09G010 02/08/2008 NAME OF PROVIDER OR SUP! LIER STREET ADDRESS, CITY, SYATE, ZIP CODE 6417 KANSAS AVE, NE CARECO 01 WASHINGTON, DC 20001 SUMMA Y STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION D (X5) COMPLETION (EACH DEFI ENCY MUST BE PRECEDED BY FULL REGULATOR CR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD US PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) W 124 Continued From page 4 W 124 150 mg every morning for depression. Interview with the Qualli ed Mental Retardation Professional ( 2MRP) on February 5, 2008 at 3:22 PM revealed first Client #3 was eighty-three years old and did no have a legal guardian and/or family members to give consent for treatment. Review of Client #3's Psychological Assessment on February 6 2008 at approximately 2:37 PM revealed that the client did not evidence the capacity to make decisions on his behalf about treatment, hal illiation, on-going medical care. and financial relaters. There was no documented evidence that he facility informed Client #1 or a legally-authorited representative, as appropriate, of the health it enefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP Additionally, it is facility failed to provide evidence that substitute I consent had been obtained from a legally recognized individual or entity, W 125 483.420(a)(3) PROTECTION OF CLIENTS W 125 RIGHTS Clients 1 and 2 have medical decision-makers. The, The facility must ensure the rights of all clients. OMRP will ensure that they are provided with Therefore, the facility must allow and encourage written information on recommended medical individual clier is to exercise their rights as clients treatments, and that they provide written informed of the facility, and as citizens of the United States. consent for treatments. The QMRP will coordinate including the right to file complaints, and the right with the DDA support coordinator to apply for a to due process... medical guardian for client #3. This STANDA ⟨□⟩ is not met as evidenced by: Based on interviews and record review, the facility failed to ensur ; that individuals who lacked the capacity to make informed decisions had received assis arroe with identifying a surrogate

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facility. (Clien) #1,#2 and #3)

decision-make for habilitation and treatment needs, for two of four clients residing in the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MED CARE & MEDICAID SERVICES

PRINTED: 02/15/2008 FORM APPROVED CMB NO. 0938-0391

AND PLAN (	T OF DEFICIENCIE OF CORRECTION	5	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) M		IPLE CONSTRUCTION IG	(X.1) DATE S COMPLE	
			<b>09</b> G010	B. WIN	1G_		02/0	9/200e
NAME OF F	PROVIDER OR SUI ) 01	PLIER		·· <b></b>	6	REET ADDRESS, CITY, STATE, ZIP CODE 1417 KANSAS AYE, NE WASHINGTON, DC 20001	<u>                                       </u>	<u>8/2</u> 008
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W 125	Continued F	nn pa	ge 5	W	125		•	_
	The finding in							
W 159	rights were p client had a li- assist them vitreatment. [5 483,430(a) Ci RETARDATI Each client's integrated, co	otecter gally strain markets W'UALIF DNI PF	ensure Client #1, #2, and #3's ad by making certain each sanctioned representative to aking decisions regarding their 124] IED MENTAL ROFESSIONAL treatment program must be ated and monitored by a ardation professional.	w ·	159			
	Based on ob. Qualified Mer (QMRP) and ensure integral client's active	ervatir tal Re record ation, d treatn					,	
	The findings  1. Cross refeensure that hall shifts.	rto W	441. The QMRP failed to evacuation drills quarterly on			1. The QMRP will ensure that the Residence of the Comment of the	fire	3 25 5 68
	<ol><li>Cross refe staffs implemant Individual Pro</li></ol>	ented	249. The QMRP failed to programs as outlined in the Plans (IPPs).		,	2. The QMRP will ensure that staff from residence and the day setting are trained implement each person's IPPs.	both the	3/25/08
	staff demons:	rated o	193. The QMRP failed to competency in the client #5's Behavior Support			3. The QMRP will ensure that staff are effectively implement client #5's BSP.	rai red to	3/25/08
,	4. Cross refe		189. The QMRP falled to	• • •1		4. The QMRP will implement training f as needed to enable them to perform the effectively, efficiently, and competently	ir caties	3/25/08
JKM CM5-284	37(02-98) Previous	entions	Obsolete Event ID: YLYG11		Fer	alily ID: 09G010		<u> </u>

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DEPARTMENT OF HE ALTH AND HUMAN SERVICES
CENTERS FOR MEDIC ARE & MEDICAID SERVICES

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AND PLAN C	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVE	eY .
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CARECO	ROVIDER OR SUPI	LIEIR		REET ADDRESS, CITY, STATE, ZIP CODE 8417 KANSAS AVE, NE WASHINGTON, DC 20031		-
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W 159	ensure that excontinuing traiperform his or and competer  5. Cross referensure that Cladaptive equip	or employee was provided with uring that enabled the employee to her duties effectively, efficiently, idy.  to W436. The QMRP failed to emit/2 was provided with necesse, ment (shower chair).		5. The QMRP will ensure that the eluccessary adaptive equipment.		25/08
W 189	The facility mu	STAFF TRAINING PROGRAM st provide each amployee with nuing training that enables the erform his or her duties effectivel competently.	W 169		3/6	35/08
	Based on obsineview, the face employee was that enabled to duties effective. The finding inc.  1. The facility hand splints waccordance will evidence below. On February 5 Client #3 was:	ailed to ensure that Client #3's so are placed on his hands in h the current physician's orders a 2008 at approximately 3:37 PM, begrived sitting in a wheelchair	oft s	1. The QMRP will ensure that the RD trained on the physician's orders on the splints, and ensure that staff implements as written.	ic use of the	35/or
	with his arms a while watching staff was obse client. Intervie revealed that t his hands tight	nd hands tightly against his body television. At 5:49 PM direct can ved to place hand splints on the vinth Residential Direction (RD) Le hand splints helps with keeping y together. Further interview with the client should wear the	∌			

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PIRINTED: 02/15/2008

DEPAR'	TMENT OF H	EALTH	I AND HUMAN SERVICES				ED: 02/15/2008
			& MEDICAID SERVICES				RM APPROVED
STATEMEN	T OF DEFICIENCIE OF CORRECTION	3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION (X2) DA	NO. 0938-0391 TE SURVEY MPLETED
			09 <b>G</b> 010	B. WI	NG.		0/00/00 ==
NAME OF F	ROVIDER OR SUI	PLIER	<u> </u>		Ter	REET ADDRESS, CITY, STATE, ZIP CODE	2/08/2008
CARECO	01				6	REET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE WASHINGTON, DC 20001	
(X4) ID PREFIX TAG	(EACH DEF	DIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPULATE DEFICIENCY)	(X5) COMPLETION DATE
	dinner time. dated Januar approximated diagnosis of Quadriplegia. Arthritis. Fur revealed an of further contratishould be plat morning after 1:00 PM and Put splints bar off." Interview with Professional: PM revealed and facility from a 2008. When the use of Clistated all staff February 13, Note: It should at from 11:03 observed to wa accordance with accordance wit	laily a Review of the move of	and should be removed by w of the current physician's on February 6, 2008 at PM revealed the client has a ral Palsy with Spastic ole Flexion Contractures, and view of the physician's orders or soft hand splints to prevent it. "The soft hand splints the client's hands in the client's hands in the criming care from 9:00 AM to be from 1:00 PM to 3:00 PM. from 4:00 PM to 8:00 PM then fred Mental Retardation P) on February 6, 2008 at 3:00 ient #3 was admitted to the provider on January 31, if all staff had been trained on a soft hand splints, the QMRP cheduled to be trained on soft hand splints in physician's orders.  908 at 5:13 PM Client #2 was Stab for constipation. The cribed Docusate Sodium 100 by at bedtline for constipation. vel tracking chart reviewed on 12:46 PM, Client #2 did not ment for three (3) days (2/1)	W	189		60 ac
	2/2, and 2/3/0.	i). Re ders S	eview of the Standing  6 for "Constitution" revealed			property leads to enemis intention needs.	3/25/08

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Event ID:YLYG11

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PRINTED: 02/15/2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDIC AIRE & MEDICAID SERVICES O<u>MB NO</u>, 0938-0391. (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09@010 02/08/200B NAME OF PROVIDER OR SUPF JER STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE CARECO 01 WASHINGTON, DC 20001 SUMMA) Y STATEMENT OF DEFICIENCIES (EACH DEFIX IELICY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) (Z) (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD FE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PRÉFIX PREFIX DATE REGULATOR' OR LSC IDENTIFYING INFORMATION) TAG TAG W 189 Continued From page 8 W 189 After two digs without a bowel movement. give prune juli a 402 by mouth two times a day for 48 hours or 2. Milk of May nesia two tablespoon by mouth two times a day PRN or 3. Citrate of Magnesia 4. Push oral fluids Interview with the facility's Licensed Practical Nurse (LPN) confirmed that staff should notify the nurse and give prone juice in accordance with the standing phys sian orders. Further interview with the LPN revealed that she was not made aware. that the client did not have a bowel movement for three days. It lerview with the Residential Director reves ed that Client #2 had a bowel movement wil also those days, but staff forgot to record it. 2. See response to W249. The QMRP will insure 2. Cross refer to W249. The facility failed to ensure that staff had received effective training in that all staff are trained on implementation ( f each implementing programs as outlined in the client's ISP as soon as the Interdisciplinary Feam 3/25/08 has formulated it. Individual Projirem Plans (IPPs). W 193 483.430(e)(3) STAFF TRAINING PROGRAM W 193 Staff must be able to demonstrate the skills and The QMRP will ensure that all staff adhere to the techniques ne sessary to administer interventions standards governing the 1:1 staffing duties. Staff to manage the imappropriate behavior of clients. who are unwilling or unable to adhere to the requirements will be removed from such duties. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review the fac lity staff failed to demonstrate competency in the implementation of Client #5's Behavior Support Plan (BSP). The finding in sludes:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MED CARE & MEDICAID SERVICES

PRINTED: 02/15/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIE OF CORRECTION	3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X: ) DATE SU COMPLE	
			<b>09G0</b> 10	B. WING		02/08	1/2008
CARECO	ROVIDER OR SU	PLIER			REET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE WASHINGTON, DC 20001		\ <u>-</u>
(X4) ID PREFIX TAG	(EACH DE	CIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)	ULE BE.	(X5) COMPLETION DATE
W 193	staff remains with the 1:1 j evidence be. On February observed to to stand on t was in the kir. The client reminutes before no time did t trail or remained by the literal or received 1:1 physically age elopement as interview with primary duttermaln within Client #5 at records on Fithat all staff: 1:1 Job dutter evidence the 483.440(c)(c). The individual opportunities self-manage:	ited to	ensure that Client #5's 1:1 ose proximity in accordance les and responsibilities as be at 4:33 PM Client #5 was he kitchen area to go outside at porch. Client #5's 1:1 staff preparing the dinner meal. If outside on the porch for two hing back into the facility. At staff leave the kitchen area to a eyesight of Client #5 as avior management plan. Availited Mental Retardation P) on February 8, 2008 at 0 AM revealed Client #6 g 24 hours a day to manage we behaviors to prevent ring self and others. Further and revealed that one of the e 1:1 staff person was to ght and/or arms length of s. Review of the staff training y 8, 2008 at 9:12 AM revealed and received training on their esponsibilities. There was no hig was successful. IDIVIDUAL PROGRAM PLAN ram plan must include ent choice and	W 193		an( offering	3/25/08
	Based on ob	ie "vati	on and interview, the facility t Client #2 was provided the		·	-	

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			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2008 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A, BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
			09G010	B. Wil	NG_		02/0	3/2008
NAME OF F	ROVIDER OR SUFF	JER				REET ADDRESS, CITY, STATE, ZIP CODE		
CARECO	0 01					417 Kansas ave, ne Vashington, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFI	(ENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAS		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDEE	(X5) COMPLETION DATE
W 247	Continued Fro	n ba	ge 10	W	247			
		ירח זכ	aking choices as part of their					
	The finding in	lu de:	S.		,			
	2008 at appro #2's 1:1 staff of Client #2 was sitting in the clinterview with normally assistraightening of Client #2 required with this task of the 1:1 staff of with organizing evidence that	intatingan abse air a he 1 s with ue to bis his he C	ns conducted on February 5, ely 4:16 PM revealed Client lizing his close in his bedroom. rved to be sleeping while the front of the bed.  1 staff revealed that Client #2 the folding laundry and scloset. The 1:1 stated that hand over hand assistance this blindness. At no time did rencourage Client #2 to assist closet. There was no lient #2 was afforded the			•		
W 249	his capabilities		management to the extent of GRAM IMPLEMENTATION	107	249			
	As soon as the formulated a cleach client mutreatment proginterventions and frequency	inite ient's st res ram no se to se	rdisciplinary team has so individual program plan, beive a continuous active consisting of needed ervices in sufficient number apport the achievement of the lin the individual program	***	K. Th-uJ	The QMRP will ensure that staff in the are effectively trained in implementing IPPs, and that residential staff ensure tencouraged to improve his self manage	clien #1's hat he is	3/25/08
	Based on obserview, the fact as outlined in it	rvatility for the line of the	s not met as evidenced by: on, interview and record alled to implement programs dividual Program Plans aree clients included in the					

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FRINTED: 02/15/2008

DEPAR	TMENT OF H	EALTH	AND HUMAN SERVICES				FRINTED	: 02/15/2008
			& MEDICAID SERVICES				C MB NO	APPROVED . 0938-0391
STATEMEN AND PLAN	Y OF DÉFICIENCE OF CORRECTION	ŝ	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. Bu		PLE CONSTRUCTION	(X3) DATE S	URVEY
			096010	B. WII	NG_		02/0	<b>18/2</b> 008
CARECO	PROVIDER OR SU	PLIER			G.	REET ADDRESS, CITY, STATE, ZIP CODE 417 KANSAS AVE, NE VASHINGTON, DC 20001		<b>072</b> 000
(X4) ID PREFIX TAG	(EACH DE	ICHENCY	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	Ib PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULL BE	(X5) COMPLETION DATE
W 249	Continued Fi	orn pa	ge 11	W:	249			-
	The finding is	-cludes	<b>5</b> :					
	Client #1 wa turkey breas! pureed during observed to a staff person, that the clien and his ADL.  On February observed during observed during turkey breast the clien and his ADL.	serve collar phis d aceive intervi is tota kills.	8 at approximately 6:22 PM d sweet potatoes, roasted d greens, and beverage inner meal. The client was total assistance from his 1:1 iew with the 1:1 staff revealed ally dependent with feeding 18 at 12:11 PM the client was chat his day program. The					
	and wheat browns observed hand assistant spoonful of formeal. Interviprogram reversillent #5 usin 1:1 staff furth	to fee ce and put to fee and put to fee and put to fee aloud the state of the state	ixed vegetable, baked fish, reed. The assigned 1:1 staff and Client #1 using hand over defenced encouraging him to raise the his mouth during the entire in the 1:1 staff at the day nat she was trained to feed dover hand assistance. The caled that Client #5 had an assistance.		-			
W 263	(IPP) dated J 2008 at appropriam that assistance, the with food to haccuracy for the accuracy for the evidence to apportunity for the participate meal on February 2008.	inuary xlinate italted italted is clien conse itant the self-r in his p	s Individual Program Plan 24, 2008 on February 7, ely 3:11 PM revealed a "with hand over hand t will raise his spoon filled th three times with 100% ecutive months." There was Client #1 was afforded the nanagement and encourage programs during the dinner 2008. DGRAM MONITORING &	W 2	63			

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			I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/15/2008 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILDING	LE CONSTRUCTION C	X3 DATE 50 COMPLE	URVEY
			09G010	B. Wil	NG		02/0	8/2008
NAME OF P	ROVIDER OR SUF	'LI 플로				SET ADDRESS, CITY, STATE, ZIP CODE		0.200
CARECO	01					17 Kansas ave, ne Ashington, DC 20001		
(X4) ID PREFIX TAG	(EACH DEF	JE NO	TEMENT OF DEPICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D 36	(X5) COMPLETION DATE
W 263	Continued Fro	w ba	ge 12	W:	263			
	are conducted	anly a len	uld insure that these programs with the written informed t, parents (if the client is a dian.					
	Based on obs review, the facommittee (Hieraure that rewith written coincluded in the The findings in	en/ati Iliny's men stricti nsem sam clude				·		
	rights committed to sent had to behavior Supporting use of present evidence with Professional (approximately not have written guardian. It so QMRP, the clibut there was	e fai en c ort P cribe Quali NIRI 1:30 n off ould ould outs :	e W124] The facility's human filed to ensure that informed obtained for the use of lan (BSP) that incorporated at psychotropic medications. If the field Mental Retardation P) on February 8, 2008 at PM revealed that Client #1 did formed consent signed by a noted, according to the sisters is "involved" in his life, idence that they had been of psychotropic medications.			1. See response to W124. The Human Rij Committee has a procedure to review the restrictive measures, including the use of psychotropic medicines; the QMRP will e such restrictive treatments for client #1 an before the HRC for approval.	us of all ensure than	3/25/08
	rights committ consent had b Behavior Supp the use of pres Interview with Professional (1	e fai en o ori P oribe tualit	e W124] The facility's human led to ensure that informed btained for the use of lan (BSP) that incorporated dipsychotropic medications. fied Mental Retardation P) on February 8, 2008 at PM revealed that Client #2 did			2. See response to #1 above.		3/25/08

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CENTE	RS FOR MEL	<u>ICAR</u> E	AND HUMAN SERVICES  MEDICAID SERVICES			FORM	): 02/15/200 MAPPROVE
STATEMEN	T OF DEFICIENCE OF CORRECTION	\$	(X1) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	FLE CONSTRUCTION	(X3) DATE S COMPL	
			096010	B, WING_			
NAME OF F	ROVIDER OR SU	PLJER		STR	EET ADDRESS, CITY, STATE, ZIP COD		08/2008
CARECO	01			64	417 KANSAS AVE, NE /ASHINGTON, DC 20001	<b>=</b>	
(X4) ID PREFIX TAG	(EACH DE	ICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 263	not have write guardian. It QMRP, the country there was informed of t	en info hould ient's no ev te use	nnned consent signed by a noted, according to the mother is "involved" in his life, idence that they had been of psychotropic medications.	W 263			
	rights commiconsent had Behavior Supthe use of properties with Professional approximately did not have guardian. The been informed medications,	tee fai neen o port P scribe Cuali QMRI 11:34 vritten are wa I of the	e W124] The facility's human led to ensure that informed obtained for the use of lan (BSP) that incorporated and psychotropic medications. Field Mental Retardation P) on February 8, 2008 at PM revealed that Clients #3 informed consent signed by a is no evidence that they had a use of psychotropic		3. See response to #1 above.		3/25/08
W 322		ıs; pro	SICIAN SERVICES  wide or obtain preventive and e.	W 322			
	Based on obs review, the fac	er/ationalists  ility fault  e for the	not met as evidenced by: on, interview and record iled to ensure general and wo of three clients included in #2 and #3)				1
	orders on Fet AM revealed t Collar" as par' Interview with	Alient a Tuary 7 Te clle of his the fac	#2's current physician's 7, 2008 at approximately 9:54 nt was prescribed a "Cervical adaptive equipment. Cility's Licensed Piratical alified Mental Retardation	1   s   1   t	I. The QMRP will ensure that the precommendations and length of time should use the cervical collar is clear SP. The QMRP will ensure that the raining on how to implement and do use of the cervical collar, and that the tave a protocol for monitoring the imposite the neck support.	the client  y stated in his  staff n ceive  cumen the	alarka

02/15/2008 06:46 FAX 2024429430

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DEPARTMENT OF HE ALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED:	02/15/2008
FORM.	APPROVED
OMB NO.	0938-0394

	of dericiencies of correction		(DENTIFICATION NUMBER:	Ι'	ILDING	LE CONSTRUCTION	COMPU	
			Q9G010	B. WI	МВ		02/(	08/2008
CARECO	PROVIDER OR SUP 0 01	LIER			641	ET ADDRESS, CITY, STATE, ZIF CODE 17 KANSAS AVE, NE ABHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFI	HENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	TX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD 3E	(X5) COMPLETION DATE
W 322	Professional approximately should wear tonly. Review Plan (ISP) and the section errevealed that bedtime and interview with refused to we will take it off, mistake of no Interdisciplinal having staff to collar while in Therapy assefuled to reflect and length of assessment if direct care stainplementation Further review had been devine documents nursing staff meck support.  2. The facility hand splints wourrent physic on February: Client #3 was with his arms while watching staff was obsocient. Interviewealed that	QIMP: Cecord of the control of the c	RP) on February 8, 2008 at 200 AM revealed that the client ervical collar during bedtime ient #2's Individual Support and December 20, 2007 under "My assistive Devices", ervical collar was to be worn at in the facility. Further DMRP revealed that the client accollar inside the facility. He DMRP stated that it was her ressing this issue to the sam (IDT) this past ISP and ument his refusals to wear the acility. Review of the Physical and dated October 12, 2007 purpose, recommendations for the use of the collar. The to provide instructions for ensure appropriate this prescribed support, and to revealed that a protocol and by the nursing staff and that was available to support the oring the implementation of this	VV	322	2. See response to W189 #1.		3/25/08

FORM CMS-2567(02-99) Previous \ arsions Obsolete

Event ID: YLYG11

Facility ID: 09G010

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Ø 020

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2008 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIE OF CORRECTION	3	(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(XI) DATE S COMPLE	
			09G010	B. WD	NG_		02/0	8/2008
CARECO	PROVIDER OR SUI	FLIER			6,	EET ADDRESS, CITY, STATE, ZIP CODE 417 KANSAS AVE, NE /ASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEF	CHENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF YAG		PROVIDER'S FLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REPERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 322	hand splints dinner time, dated Januar approximatel diagnosis of Quadriplegia, Arthritis. Fur revealed and further contrashould be planoming after 1:00 PM and	ent that laily all Review / 2008 / 2037 Xerebrough Nutting their reder for the many	ge 15 at the client should wear the old should be removed by wof the current physician's on February 6, 2008 at PM revealed the client has a all Palsy with Spastic ple Flexion Contractures, and view of the physician's orders of soft hand splints to prevent the client's hands in the prining care from 9:00 AM to be from 1:00 PM to 8:00 PM then	W:	322			
W 331	Professional PM revealed facility from a 2008. When the use of Cli Nurse, the Qi be trained on 483.460(c) N The facility m services in ar This STAND, Based on star facility failed is accordance v.	QMRI hat Granther asked ant #3 VELP s Febru JELSIN ust proceed and the English interpretable and the English the Chart in	ovide clients with nursing race with their needs.  In the needs of two of two clients in the land Client #2)	Wä	331	See response to W189.		3/25/08
	_		2.2. The facility's nursing staff					

FORM CMS-2567(02-99) Previous \* emions Obsalete

Event ID: YLYG11

Pacifity ID: 09G010

if continuation sheet Page 16 of 20

02/15/2008 06:47 TAX 2024429430

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**2**021

DEPARTMENT OF HE L'TH AND HUMAN SERVICES

PRINTED: 02/15/2008 FORM APPROVED

CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G010 02/08/2008 NAME OF PROVIDER OR SUPFLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE CARECO 01 WASHINGTON, DC 20001 SUMMAI' Y STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION PREFIX (EACH DEFIL IENCY MUST BE PRECEDED BY FULI (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATOR' OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 1EE W Continued Froin page 16 W 331 failed to ensure that Client #3's soft hand splints were worn in a coordance with the current physician's orders. W 356 483.460(g)(2) COMPREHENSIVE DENTAL W 356 TREATMENT The OMRP will coordinate with the medical team The facility must ensure comprehensive dental to ensure that clients receive comprehensive dental 3/25/08 treatment sen, coe that include dental care treatment services. needed for rel of pain and infections. restoration of leeth, and maintenance of dental health. This STANDA RD is not met as evidenced by: W 436 483.470(g)(2) SF'ACE AND EQUIPMENT W 436 The OMRP will ensure that the client has a ! hower The facility must furnish, maintain in good repair, 3/25/08 chair as recommended in the PT assessment and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinar / team as needed by the client. This STANDA (C) is not met as evidenced by: Based on observations, interview and record review, the fac lity failed to ensure that Client#2 was provided with necessary adaptive equipment (ahower chair) The finding includes: Observations conducted on February 5, 2008 revealed Clien: #2 was blind and required assistance wit I mobility and Adaptive Living Skills

FORM CMS-2567(02-99) Previous V :rsions Obsolete

(ADL). Interview with his assigned 1:1 staff on February 6, 2008 at 3:01 PM revealed that Client #2 is able to complete some ADL skills with hand

Event ID: YLYG11

Facility ID: 09G010

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**2**022

PEINTED: 02/15/2008

			AND HUMAN SERVICES				FORM	APPROVED
	RS FUR MEDI TOP DEFICIENCIE	<u> FRE</u>	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) N		PLE CONSTRUCTION	(X3 DATES	D938-0391
AND PLAN (	OF CORRECTION		IDENTIFICATION NUMBER:	1	ILDING		COMPL	
			09GD10	B. Wil	NG		02/0	08/2008
NAME OF F	PROVIDER OR SUF	'LI ER			64	EET ADDRESS, CITY, STATE, ZIP CODE 117 KANSAS AVE, NE VASHINGTON, DC 20001	<u></u>	
(X4) ID PREFIX TAG	(EACH DEF	AENC,	ATÉMENT OF DEFICIENCIES Y MUST HE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD 3E	(X5) COMPLETION DATE
W 441	over hand as putting on clo showers. Re approximately. Therapy (PT) 2007. Accord recommende and a shower Interview with Professional approximately not have a sh documented with the show recommende 483.470(i)(1)  The facility m varied condition. This STANDA based on obsercord verification of the finding in Review of the February 6, 2 drills were contained at 2:10 PI least five metal with the QMR through the kills.	islan hes, to 10:3	ce including toothbrushing, washing/drying hand, and review on February 7, 2008 at 60 AM revealed a Physical issment dated October 12, of the assessment, it was a Client #2 utilize a grab bars to assist with showering. Qualified Mental Retardation (P) on the same day at PM revealed that Client #2 did chair. There was no note that Client #1 was provided air to assist with showering as the PT assessment. CUATION DRILLS old evacuation drills under the facility failed to hold ider varied conditions.		436	The QMRP will ensure that the RD he cvacuation drills on all shifts at least under varied conditions.		3/25/68

FORM CMS-2567(02-99) Previous \ rs ons Obsolete

Further review of the fire drill record revealed that

Event ID; YLYG11

Facility ID: 09G010

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DEPARTMENT OF HE ALTH AND HUMAN SERVICES

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**2**023

PRINTED: 02/15/2008

			& MEDICAID SERVICES				FORM ON B NO	APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	JRVEY
			09G01D	B. WI	√G _		02/0	8/2008
NAME OF P	ROMDER OR SUPI	JER	· ·			REET ADDRESS, CITY, STATE, ZIP CODE		
CARECO	0 01 .					417 KANSAS AVE, NE VASHINGTON, DC 20001		
(X4) ID PREFIX TAG	(EACH DEFI	IEMC/	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDEE	(X5) COMPLETION DATE
W 441	Continued Fro	n pa	ge 18	w.	441			
W 460	the side door had not been shift. There w drills were held	xit a sed ss no Lnd	nd the exit on the upper level at least quarterly on each peridence that evacuation ler varied conditions.  D AND NUTRITION		460			
		i teit	ceive a nourishing, ncluding modified and d diets.			The QMRP will ensure that staff are tre properly and accurately measure the cl- servings so that his diet conforms to the recommended by the Nutritionist.	ient's food	3/25/08
	Based on obserview, the factories address:	:rvati ility fi d the	s not met as evidenced by: ion, interview, and record allied to ensure therapeutic anutritional needs of one of ample. (Client #2)					
	The finding in	lude	s;					
	Client #2 was turkey breast, beverage duri preparing the portions that v with the staff at that Client #2 how do you kr to Client #2, the doing this for approximately was prescribe cholesterol, ch Nutritionist's a was prescribe cholesterol, cholesterol	lerve colla g the netal as: se app s on over we state long ers of appears to a poppears as a long ers of a long er	at approximately 6:22 PM and sweet potatoes, roasted and greens, and water as his a dinner meal. The staff did not measure the food erved to Client #2. Interview proximately 6:15 PM revealed a special diet. When asked that amount of portions to give aff stated "I just know, I've been a time." Review of the current on February 7, 2008 at AM revealed that Client #2 800 calorie low fat, lowed diet. Review of the sment revealed that Client #2 800 calorie low fat, lowed diet. There was no taff measured the food					

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DEPAR	TMENT OF HI	ALTH A	AND HUMAN :	SERVICES				PRINTE	D: <b>02/15/2</b> 008
CENTE	RS FOR MED	CARE (	MEDICAID S	ERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMEN	T OF DEFICIENCIE OF CORRECTION		X1) PROVIDER/SU IDENTIFICATION	IPPLIER/CLIA	(XZ) M		PLE CONSTRUCTION	(X:-) DATE (COMP)	SURVEY
		-	090	<b>30</b> 10	B. Wil				
NAME OF F	ROMDER OR SUI	=L ERL				ста	CET ADDREDO OPOZ OTZER DE ACE	02/	08/2D08
CARECO	01			·		84	eet address, city. State, zip code 117 Kansas ave. Ne (Ashington, DC 20001		
(X4) ID PREFIX TAG	I (EACH DEF	$\square FNCYM$	MENT OF DEFICI UST BE PRECEDE DENTIFYING INF	こうりく ミニコ	ID PREF TAG	×	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF CORRECTION OF CORRECTION OF THE APPLICATION OF CORRECTION OF THE APPLICATION	אוווי היים	COMPLETION DATE
W 460	Continued Fr portions that meet his diet	vere se	rved to the clie	ent in order to	W	160			
·								-	
				·					
RM CMS-250	7/ng on) dies le	<del></del>			<u>.</u>				
n mii Ç#13=230 /	7(02-99) Previous Vr	ас па <i>О</i> Ба	oleța	Event ID: YLYG11		Facilit	y ID: 09G010 If continu	lation sheet I	Page 20 of 20

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PFIINTED: 02/15/2008 FORM APPROVED

AND PLAN	T OF DEFICIENCIÉ OF CORRECTION	DENTIFICATION NUI		A. BUILDIN B. WING		(X3 DATE S COMPLI	
	rovider or eupi	LIER		DRESS, CITY, . I <b>SAS AVE. I</b>	STATE, ZIP CODE	- 1 - 1	_
CARECO	0 01			TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEF	LY STATEMENT OF DEFICIENCIES JENCY MUST BE PRECEDED BY 7 OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD 1E	(X5) COMPLETE DATE
! <b>9</b> 00	5, 2008 through was initiated a process. A reselected from with various discovery were to with one clien programs, as administrative.	rvey was conducted from the February 8, 2008. The sing the fundamental surviction sample of three clies a client population of five subilities. The findings of ased on observations, into staff in the home and the well as a review of client of records, and incident reports were also reviewed.	survey  'ey  nts was  males the erviews ee day ecords, orts.	I 000			
1 042	Modified diets (b) Planned, I who have reciand This Statute is Based on obserview, the Glidets address two clients in On February Casident #2 vickey breast, beverage durited.	shall be as follows: repared, and served by inved instruction from a distriction from a distriction, interview, and recommended the nutritional needs of neisample. (Resident #2) ludes: , 2008 at approximately 6 as served sweet potatoes collard greens, and watering the dinner meal. The smeal did not measure the	dividuals etitian; cord rapeutic one of :22 PM , roasted as his		The QMRP will ensure that staff are properly and accurately measure the servings so that his diet conforms to recommended by the Nutritionist.	client'; food	3/25/08
	portions that with feveraled that When asked portions to give just know, I've allon Administrations.	as served to Resident #2. the staff at approximately Resident #2 is on a specie ow do you know what am a to Resident #2, the staff been doing this for a long	6:16 PM If diet ount of stated "I Itime,"		TITLE		(X6) DATE
ABORATORY		ROMDER/BUPPLIER REPRESEN			Director of Disability Sovia	H continue	105   08

**2**023

02/15/2008 06:47 FAX 2024429430

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**2**026

F'RINTED: 02/15/2008 FORM APPROVED

ND PLAN	NT OF DEFICIENCE OF CORRECTION	;	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ik/clia Mber:	(XZ) MUL A. BUILDI B. WING		(23) DATE S COMPL	
AME OF F	PROVIDER OR SU	(D) (Iso	09G010	STREET A			02/0	<u>8/2008</u>
AREC		FLIER	,	6417 KA	NSA9 AVE, GTON, DC	STATE, ZIP CODE NE 20001		
(X4) ID PREFIX TAG	I CEACH DE	ICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	K21 (1 )	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE	ON SHOULL: BE HE APPROPRIATE	(XE) IGMOD TAG
1042	Review of the February 7, a revealed that calorie low far Review of the that Resident low fat, low cono evidence	Q()8 at Q()8 at Reside t, ow c Nutrit #2 wa Toleste hat the were se	nt physician's orders approximately 9:54, ent #2 was prescribe cholesterol, chopped ionist's assessment is prescribed a 1800 erol, chopped diet. The staff measured the erved to the client in	AM d a 1800 diet. revealed calorie here was	1 042	·		
I 091	Housekeepir be well const	) and r uated,	PING naintenance equipm properly maintained notion for which it is	and	1091	The QMRP will ensure that the or replaced.	doorbell is epaired	وولن
·	Based on oba failed to mair GHMRP in a. and sanitary	ervatio ain the h a sat hanner	•	a facility of the				
	Mental Retarr the environm 2008 revealer	nd inte ation F tital wa that th	erview with the Qualif Professional (QMRP) alk through on Febru se door bell located a s observed not funct	during ary 8, at the				,
	3505.5 FIRE : Each GHMRF order to test to four (4) times	snall d	conduct simulated fin ctiveness of the plan	e drills In at least	l 135	The QMRP will ensure that the evacuation drills on all shifts at under varied conditions.	RD holds fire least quarterly	3/351

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PRINTED: 02/15/2008 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) (ATE SUI COMPLET	
		09G010			02/08	/2008
NAME OF P	ROVIDER OR SUPPI	IER STREET AD	DRESS, CITY, S	STATE, ZIP CODE		,
CARECO	0 01		ISAS AVE, N TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFIC	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OF, LSC IDENTIFYING INFORMATION)	IÒ PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD EI:	(X5) COMPLETE DATE
1 135	Continued Fro-	ט age 2	l 135			-
	Based on obserecord verifica:	not met as evidenced by: vations, staff Interview, and on, the GHMRP failed to hold a under varied conditions.	•			,
	The finding inc	ucles:				
	February 6, 20 fire drills were door exits. Ini Retardation Pr day at 2:10 PM least five meth with the QMRF through the kits upper level of a Further review the side door a had not been ushift. There we	acility's fire drill records on 18 at 1:16 PM revealed that the conducted via the front and back arriew with the Qualified Mental ofessional (QMRMP) on the same revealed that the facility had at od of egress. Further interview revealed that there's an exit hen (Side Door) and exit on the re facility leading to the back yard of the fire drill record revealed that dt and the exit on the upper level sed at least quarterly on each sine evidence that evacuation under varied conditions.				
1 206	Each employe. annually there: certification the performed and	NNEL POLICIES  , prior to employment and fter, shall provide a physician 's tall health inventory has been that the employee 's health status or her to perform the required	1 206		·	
Health Recul	Based on inter-	not met as evidenced by: few and record review, the to ensure that all staff had current ea on file.				· · · · · · · · · · · · · · · · · · ·

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	OF CORRECTION		DENTIFICATION NU	MBER;	A. BUILDI		- CON	'E SURVEY IPLETED
AME OF F	ROVIDER OR SUPI	∸ ⊔E:R		STREET AD	DRESS CITY	STATE, ZIP CODE	0	2/08/2008
CARECO				6417 KAN	ISAS AVE.	NE		
(X4) ID PREFIX TAG	(EACH DEFI	TEMOY N	EMENT OF DEFICIENCIE MUST BE PRECEDED BY CIDENTIFYING INFORM.	'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD I E HE APPROPR ATE	(X5) COMPLET DATE
1206	Continued Fro	n pag	e 3		1 206			~-
	The findings in	clude:						
	February 8, 20 revealed the 0	08⊩at a HMRF	sonnel files conductance of the sound of the	PM vidence	-	1. The Human Resources Direct Staff #4 has a current health cent		at 3/25
1 <u>22</u> 7	3510.5(d) ST#	FF TR	RAINING		l 227			
	Each training : limited to, the	regrar o) owir	m shall include, but ng:	not be		,		
	(c) Infection ca	ntrol fo	or staff and resider	its;				
	Based on recr	d reviev	net as evidenced by ew, the GHMRP fa w current training in ees.	iled to				
	The findings in	olude;						
	records/trainin	) recor	, review of personn rds revealed that th without current Firs	e		1. The Human Resources Direc	tor will coso e th	of.
	1. Current CPF	:-S#	4 and \$ #16			Staff #4 and #16 have evidence file.	of current Cl'R o	n 3/25
- f <b>3</b> 92	3520.2(b) PRO PROVISIONS	FESS	ION SERVICES: G	ENERAL	I 392			
	professional sunecessary professional sunecessary profescordance wiindividual habil	affito c assion h the q tation	iave available qualicany out and monitical interventions, in goals and objective plan, as determine rdisciplinary team.	or s of every d to be				

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AND PLAN	IT OF DEFICIENCIE OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENT/F/CATION NUM 09G010	MBER:	A. BUILDIN B. WING		(X3) DATE SU COMPLE 02/08	
CAREC	PROVIDER OR SUP	'LIIER		6417 KAN	SAS AVE, N TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEF	CIENCY	TEMENT OF DEFICIENCIE  Y MUST BE PRECEDED BY  SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD 3E	(XS) COMPLETE DATE
1392	professional: limited to, the trained, qualification of Coldisciplines or (b) Dentistry.  This Statute Based on obserview, the Gomprehensimaintenance residents in the findings.  1. Review of February 7, 2 revealed a de 2007. The concept and 2007. The concept and 2007 are commended pre-authorize interview with Professional Practical Nurrapproximatel #1 had not be October 3, 20 stated that the for dental serfollowing up a survey, the fare sident #1 There was all	ervice ed, a mission of the treatment of	es may include, but rivices provided by included by included by included as required law in the following of services;  met as evidenced by including interview, and repaired to ensure atment services for the interview of mple. (Client #1 and interview)	dividuals and by  cecord  decord  deco	1392	1. The QMRP will coordinate with the Support Coordinator to acquire the prisuthorization required for Medicaid padental services on a timely basis, and the dentist also provides an appointment of within the prior authorization period.	or syme it for hat tie	3/35/0

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STATEMENT OF DEFICIENCIE: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING B. WING 09G010 02/08/2008 NAME OF PROVIDER OR SUPILIER STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE CARECO 01 WASHINGTON, DC 20001 SUMMA: Y STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFI: IENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD LE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATOR 'CR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY 1392Continued From page 5 1392 2. On Februa, y 5, 2008 at approximately 3:36 PM Resident 2 was observed to have 3/25/08 2. See response to #1 above. discoloration round his teeth. Review of Resident #2's medical records on February 7, 2008 at appre dimately 9:54 AM revealed a dental consult dated December 4, 2006. According to the consult, the dentist recommended scaling due heavy moders to calculus deposits, and indicated she"will subm : pre-authorization to Medicald for approval." Fu ther record review revealed another denta consult dated November 6, 2007. According to the consult, there was slight mobility with teeth #10 and moderate calculus deposits noted. The dentist recommended scaling and "will submit pr ⊱authorization to Medicaid for approval." Inf :rview with the Qualified Mental Retardation P of essional (QMRP) and facility's Licensed Practical Nurse (LPN) on February 8, 2008 at appro: innately 1:00 PM confirmed that Resident #2 haid not been back to the dentist since December 4, 2006 almost a year later. The QMRP stated het the facility was still waiting for approval for dental services (Scaling) and that she was following up with this issue. At the time of the survey, he facility failed to provide evidence that Resident #1 received timely dental services. The e was also no evidence of the facility's effort: to assist with the obtainment of the pre-author zation. 1394 3520.2(d) PROFESSION SERVICES: GENERAL 1394 **PROVISIONS** See response to 1042. 3/25/08 Each GHMRP shall have evailable qualified professional s aff to carry out and monitor necessary pro essional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by he interdisciplinary team. The professional s : n/ices may include, but not be Health Regulation Administration STATE FORM

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KIND PLAN	ATEMENT OF DEFICIENCIE DELAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  U9/G010			(X2) MULTIF A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE 3 COMPL	
IAME OF E	ROMDER OR SUPI					02/0	)8/20 <u>0</u> 8
CARECO			6417 KAN	NSAS AVE, N STON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFI)	Y STATEMENT OF DEFICIENCY LENCY MUST BE PRECEDED BY COR LSC IDENTIFYING INFORM	FILL	ID PREPIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD HE THE APPROPR ATE	(X5) COMPLE DAYE
1394	trained, qualified District of Coldisciplines or a disciplines or a conference of the conference of th	e services provided by in ed, and licensed as requimble law in the following literal of services:  The root met as evidenced by alled to ensure that qualificational interventions, in the clients needs, the goal of the processary by the y team.	red by  fied  ored  Is and  Is plan, as  i:22 PM  is, roasted  is staff  is food  is food  is to plan, as  fied  is to plan, as	1394	DEFICIENC	ΣΥ)	
	February 7, 201 revealed that I calorie low fat, I Review of the that Resident :: low fat, low char no evidence the	DE: at approximately 9:54 esident #2 was prescribe low cholesterol, chopped lutritionist's assessment 2 was prescribed a 1800 desterol, chopped diet. The at the staff measured the ere served to the residen	AM ed a 1800 diet. revealed calorle There was food				

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	T OF DEFICIENCIE OF CORRECTION	IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN B. WING		OMPLETED			
			09G010				02/08	/2008		
NAME OF P	ROVIDER OR SUF	*LIER		STREET ADD	RESS. CITY,	STATE, ZIP CODE				
CARECO	0 01				ISAS AVE, NE STON, DC 20001					
(X4) ID PREFIX TAG	(EACH DEFI	RY STATEMENT OF DEFICIENCIES I DISINCY MUST BE PRECEDED BY FULL Y OR LISC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ACTION SHOULD BE COMPLETE DATE			
1 395	Continued Fr	utri page 7			1 395					
I <b>3</b> 95	3520,2(e) PR PROVISION:	OFESSION SERVICES: GENERAL			1 395					
	professional . necessary pr. accordance v individual hali necessary by professional : limited to, the trained, quali	taff to fession ith the ilitation the in ervice se ser ed, an ambia	I have available quality carry out and monitorial interventions, in a goals and objective in plan, as determine terdisciplinary team. As may include, but no licensed as requiral law in the following of services:	or s of every d to be The tot be dividuals						
	The GHMRP professional and accordance violactives of determined to interdiscipling	tailed taif care fession it climates it cl	met as evidenced by to ensure that qualificanted out and monitoral interventions, in ents needs, the goal individual habilitation coassary by the monitoral for two of three respect (Resident #2 and pole. (Resident #2 and to ensure the second continuity).	ed ored Is and I plan, as sidents						
	The findings in the findings in the findings in the following in the first term in t	r to 32 ian's 9:54 Cervionent fical Nation 106: additing port F		nt #2's 7, 2006 at 1nt was his facility's diffed 9 on 0 AM 00ervical		1. The QMRP will ensure that the purp recommendations and length of time the should use the cervical collar is clearly ISP. The QMRP will ensure that the statraining on how to implement and docur use of the cervical collar, and that the number of the neck support.	e client stated in his aff receive ment the	3/25/08		

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STATEMENT OF DEFICIENCIE   AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA - IDENTIFICATION NUMBER:		A BUILDIN	·	(X3 DATE SURVEY COMPLETED	
09 <b>G</b> 010					B. WING_		02/08/2008	
NAME OF PROVIDER OR SUPILIER STREET			STREET AD	DDRESS, CITY, STATE, ZIP CODE				
CARECO	01				isas ave, i iton, dc 2			
(X4) ID PREFIX TAG	(EACH DEF	:IENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPRIES OF THE APPROPRIES OF THE APPROPROPRIES OF THE APPROPRIES OF	ULD ∃≝	(X5) COMPLETE DATE
1 396	Continued Fr	•	_	ı	1 395			
	"My assistive collar is to be facility. Further revealed that inside the facilitated that it withis issue to be past ISP and refusals to we Review of the dated Octobe purpose, receive use of the provide instruit appropriate in support. Fur protocol had I and that no disupport the ni	Deivide worm at Internet Inter	T under the section eges", revealed that the at bedtime and when arrive with the QMRI lient will not wear the He will take it off. The er mistake of not additionally Team (ag staff to document he collar while in the factal Therapy assessing 2007 failed to reflect andations and length of the assessment of the fordirect care staff the nect care staff the tation for this preserview failed to reveal developed by the nurentation was available staff menitoring of this neck support for	e cervical in the collar e QMRP dressing (IDT) this his acility, ment the of time for ealied to to ensure scribed led that a sing staff e to he	·	2. The QMRP will ensure that the RD		
	ensure that C	lent #	22.2. The facility fail #3's soft hand splints a with the current phy	were	1	trained on the physician's orders on the splints, and ensure that staff implement as written.	use of the	<i>ब्रीवर्ड 108</i>
I 422	Each GHMRF and assistant the resident This Statute I Based on obsi review, the fai	shale to restrict the state of	ION AND TRAINING provide habilitation, esidents in accordant vidual Habilitation Planet as evidenced by lon, interview and recalled to implement providence of the same of the	training ice with an. cord rograms	l 422	The QMRP will ensure that staff in the ere effectively trained in implementing IPPs, and that residential staff ensure tencouraged to improve his self manage	client#1's hat he is	<i>३/३५/७</i> ४
Health Regula	(IPPs), for on- sample, (Res	ecttl Ident	ndividual Program Pla pree clients included (#3)	in the	D068	YLYG11	l pontinunti	on sheet 5 of 70

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STATEMENT OF DEFICIENCIE: (X1) PROVIDER/BUPPUER/CLIA AND PLAN OF CORRECTION UMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X2) DATE SURVEY COMPLETED			
09G010				B. WING _	02/08/			2008		
					STATE, ZIP CODE					
					NSAS AVE, NE STON, DC 20001					
(X4) ID PREFIX YAG	SUMMAILY STATEMENT OF DEFICIENCIES (EACH DEFILLIENCY MUST BE PRECEDED BY FULL REGULATOR ( OR LSC IDENTIFYING INFORMATION)			FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	MDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD 3E EFERENCED TO THE APPROPR ATE DEFICIENCY)			
1 422		n m page 9			1 422					
	REGULATOR ( CIR LSC IDENTIFYING INFORMATION)									
ealb Regul	ation Administration						· .			

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## **CARECO**

HEALTH CARE PROVIDERS 8115 FENTON ST., SUITE 203 SILVER SPRING, MD 20910 (301) 565-9400 FAX (301) 565-4541

TO: Michael D. Walker

Sharon Mebane Fatricia Vanburen

FR: Marsha Thompson

DT: Feb. 25, 2008

RE: Plan of Correction

Hi, Al:

Please see the attached POC for Careco 01, located at 6417 Kausas Avenue, NE DC 20001

This PDC is being transmitted to you via fax.